Wisconsin Opioid Project ECHO
Session Agenda

Zoom link to join from PC, Mac, iOS or Android**:** https://echo.zoom.us/j/156261634

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Zoom Meeting ID: 156 261 634

For attendance purposes please text the following code: SOCLOL to 608-260-7097

Session Date: 6/15/2018

Today's Didactic Topic and Presenter:
Alcohol Misuse in the setting of daily prescription opioid use or MAT by Christopher R. Nicholas, Ph.D.

- 12:30 PM: Attendance text-in –
  Introductions
- 12:45 PM: Case #1 & discussion
- 1:00 PM: Case #2 & discussion
- 1:15PM Didactic Presentation
- 1:30 PM: End of Session

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Wisconsin Opioid Project ECHO

May 2018 – June 2018
Live Webinar

Session Date: 6/15/18
Presenter: Christopher Nicholas, Ph.D.

Provided by the:
Wisconsin Department of Health Services
University of Wisconsin Department of Family Medicine and Community Health
University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience and Scope of Practice:
Physicians, advance practice nurses, physician assistants, nurses, pharmacists, and social workers. The audience includes both UW and non-UW clinicians and staff.

Statement of Need and Purpose:
Opioid-related complications are at crisis levels with no signs of abatement. Rural patients and providers experience particular management challenges due to a lack of resources and expert knowledge.

Elements of Competence:
In addition to knowledge, this activity has been designed to change learner competence and performance.

Learning Objectives:
As a result of this educational regularly scheduled series, it is expected that participants will:

- Understand the potential risks and benefits of chronic opioid prescribing
- Review appropriate opioid prescribing and monitoring practices
- Discuss evidence-based practices related to opioid withdrawal management
- Develop skills in the management and care coordination for patients with opioid use disorders
- Review opioid overdose prevention and intervention strategies
- Discuss the management of OUD in pregnancy
- Understand the effectiveness and logistics of office-based opioid treatment with buprenorphine and treatment services
- Understand the role of medication assisted therapies, such as methadone, naltrexone, and buprenorphine in the management of OUD
- Discuss the management of OUD in pregnancy

Name/Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?
Briana Kleinfeldt, RSS Coordinator	No relevant financial relationships to disclose	No
Randy Brown, RSS Chair, Program Director	No relevant financial relationships to disclose	Yes
Maireni Cruz, Content Expert, Addiction Medicine Physician	No relevant financial relationships to disclose	No
Chris Nicholas, Content Expert, Psychology-SUD/Mental Health Counselor	No relevant financial relationships to disclose	No
Elizabeth Collier, Content Expert, Social Worker	No relevant financial relationships to disclose	No
Paul Hutson, Content Expert,	No relevant financial relationships to disclose	No

Pharmacy		
Ritu Bhatnagar, Content Expert, Psychiatrist	No relevant financial relationships to disclose	Yes
Melissa Ngo, Content Expert, Pharmacist	No relevant financial relationships to disclose	No
David O'Donnell, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Susan Mindock, Content Expert, AODA Counselor	No relevant financial relationships to disclose	No
Sheila Weix, Content Expert, Nurse Practitioner	No relevant financial relationships to disclose	No
Kim Sprecker, OCPD Staff	No relevant financial relationships to disclose	No

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In support of improving patient care, the University of Wisconsin–Madison ICEP is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

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Opioid & Addiction Treatment ECHO Patient Case Presentation

***Please do not attach any patient-specific files or include any Protected Health Information.**

1-Date: 6/15/18

2-Presenter: Maireni Cruz

3-ECHO ID:

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: Suggestions on Behavioral treatment and continuing MAT.

Demographic Information:

6-Age: 38

7-Gender: Male

8-Education/Literacy: High School

9-Income source: Self Employment. Landscaping and painting

10-Insurance: HMO/MA

11- HPI:

Patient is a 38 y/o male with PMH significant for OUD, Cocaine use disorder, depression..
Here today to discuss about MAT for opioid use disorder.
Started using oxycodone when he was about 16-17 y/o for kidney stone pain. Was using oxycodone/morphine up to 2-3 80 mg oxycodone a day, prescribed by his pcp. After a years of using same prescription started getting medication off street and did that for about 10 years.
When he turned 30 decided to stop using pills and locked himself in a hotel room for a week but got so sick that he called his friend and gave him a heroin shot.
Since then he started using 1/2 g heroin IV daily.
He went to Hope Haven residential treatment for 30 days 6 years ago, then transitioned to Chris Farley House fo 3 months and was attending NA meetings.
Also started using suboxone off the street between 4-8 mg a day and he is still using that dose.
Denies any recent heroin use but had a prescription for oxycodone march 24.
Started using cocaine on and off when he was about 28 years old and now using 2 times per weeks.

12-Social History:

Alcohol: denies
Nicotine: use to chew tobacco. Quit 1 year ago
Marijuana: denies
Cocaine: as above
Methamphetamine: denies
Benzos: denies
Hallucinogens: denies

IVDU: yes

13-Housing:
Currently living with Parents

14- **Substance Use History:**
As above

15- Consequences of Substance Use:

- Social/occupational/educational:
  OWI
  Probation in the past
  Financial
- Physical (including evidence of tolerance/withdrawal):
  W/D and tolerance

16- Behavioral Health Interventions that have been tried:

Treatment history: Hope haven residential tx 6 years ago, Chris Farley house for 3 months, NA meetings in the past

17-Medications Tried for Relapse Prevention? (Specify):

Buprenorphine/Naloxone treated in 2016 and was slowly taper due to non compliance, no shows and continued positive for cocaine in urine

18-

Current Medications:	**Medical/Behavioral Health Diagnosis:**
Buprenorphine/Naloxone 12 mg	OUD

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19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Great Family support Stable Job	

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.):

none

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

UDS positive for cocaine since March.

Positive Hep C. Genotype 1. Viral load 3,991,000

Mild Elevated AST @ 40 in april

22-Prescription Monitoring Program Pertinent Findings:

None

23-Proposed Diagnoses:

Severe OUD

Moderate Cocaine Use Disorder

Chronic Hepatitis C,

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24-Patient Goals for Treatment:

UNK

25- Proposed Treatment Plan:

By initialing here _____ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

DSM 5 Criteria for Substance Use Disorder

A use disorder is characterized by maladaptive use resulting in repetitive consequences over the previous 12 months. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (American Psychiatric Association 2013)

1. Taking the substance in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)

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11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Opioid & Addiction Treatment ECHO Patient Case Presentation

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1-Date: 5-18-18

2-Presenter: Director Sheila Weix, MSN, CARN

3-ECHO ID: 1648

4-Have you presented this patient during this teleECHO clinic before? No

5-PLEASE STATE YOUR MAIN QUESTION FOR THIS PATIENT CASE: What should we do next (in terms of MAT or other interventions) to assist this person in managing his SUDs?

Demographic Information:

6-Age: 60

7-Gender: Male

8-Education/Literacy: High School graduate with some technical school degree

9-Income source: He is on disability for a combination of his back, HIV status, dyslexia, and history of depression. He received disability in 1995.

10-Insurance: Forward Health and Medicare

11- HPI: Opioid addiction- current drug of choice is injecting suboxone. Started initially with our system in pain clinic as early as 2001-2002, returned 2012-16, and now again in 2018 at FHC. Many years ago was involved with a methadone clinic in Arizona. Per patient report he was drug free from early 1990s until 2007/08.

Medically complex:

Lumbar spine foraminal stenosis with chronic low back pain.

Type 2 diabetes; dx'd approx. 2005.

Spinal stenosis; cervical spine.

HIV infection; on suppressive med Rx.

Hepatitis C infection; resolved after treatment.

Hypertension.

Insomnia, chronic.

Depression.

Tobacco use disorder.

Opioid use disorder.

Alcohol use disorder; resolved.

Injection drug use.

Necrotizing fasciitis Right forearm; complication of injection drug use.

S/P surgical debridement and skin grafting Right forearm.

COPD.
S/P full mouth dental extraction.
S/P ORIF mandibular fracture.

12-Social History: Worked as a machinist prior to disability. Divorced when his children were 1 and 2 years old. Ex-wife kidnapped his children and lived in hiding for 13 years. Son came back to live with him as a teenager. His children are now in their 30 and his son has fairly frequent contact with him despite living a distance away. Has some family ties. Does report a close friend network. Likes to fly remote control planes.

13-Housing: He lives in a house but is 3 months or more behind in his bills.

14- **Substance Use History:** As of March 2018: Currently the patient is using Suboxone, heroin, other opiates such as Dilaudid, cocaine and crack. He started using these 4 drugs around the age of 33. He uses all 4 drugs, injecting them, except for the Suboxone medication. Patient stated he used heroin about 3 weeks ago and he uses $60.00 worth at a time with the other opiates such as Dilaudid and whatever else he can get his hands on with the Suboxone. He goes through $300-$500 worth a month and he uses those IV. With the crack cocaine, it is $300-$500 a month and it is usually a couple times a week and he injects those drugs. His last use of Suboxone was this morning. Patient switches from 1 drug to the other to kind of avoid withdrawal symptoms. He did state that he likes the uppers versus the other types of medications.

15- Consequences of Substance Use:

- Social/occupational/educational:

Disabled
Divorced
Behind in his bills

- Physical (including evidence of tolerance/withdrawal):

HIV positive from IV drug use
Hep C positive
Recent welfare check d/t call to clinic about overusing his sleeping medication and wanting to die. EMS transport to ER.
Detox at inpatient unit, 4/2018

16- Behavioral Health Interventions that have been tried:

Patient attended a medication assisted treatment program years ago when he was out in Arizona. It was roughly a year that he was there. He was on methadone at that time and that was in the late 1980s. Then he moved back to Wisconsin in the early 1990s, was clean and free from drug use until roughly 2007-2008 and he relapsed and has been using ever since.

Patient identified that he has been diagnosed with depression. He thinks that he is on medication for his depression but he could not remember for sure.

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17-Medications Tried for Relapse Prevention? (Specify): Methadone in the past, Suboxone, Vivitrol

18-

Current Medications:	**Medical/Behavioral Health Diagnosis:**
Acetaminophen 650mg Tablet Sustained Release Sig: 1 Tablet(s) (650 mg) by mouth four times daily for 1-2 weeks then as needed	Pain
Albuterol Sulfate (Ventolin HFA®) Inhalation 90mcg/Actuation HFA Aerosol Sig: 1 or 2 Puff(s) by mouth every 4 to 6 hours as needed for pneumonia and wheezing	COPD
Alum-Mag Hydroxide-Simeth (Maalox®) 200-200-20mg/5 mL Suspension Sig: 30 Milliliter(s) by mouth every four hours as needed	GERD
Aspirin 325mg Tablet, Delayed Release (E.C.) Sig: 1 Tablet(s) (325 mg) by mouth once daily	CAD
Atorvastatin 10mg Tablet Sig: 1 Tablet(s) (10 mg) by mouth once daily	Hyperlipidemia
Blood Sugar Diagnostic (Accu-Chek Aviva Plus Test Strip®) Miscell. (Med.Supl.;Non-Drugs) Strip Sig: 1 Strip(s) up to four times daily and as needed	DM
Cholecalciferol (Vitamin D3) 50,000unit Capsule Sig: 1 Capsule(s) (50,000 unit) by mouth once weekly for 6 weeks for Vitamin D deficiency.	Vit D deficiency
DULoxetine (Cymbalta®) 60mg Capsule, Delayed Release(E.C.) Sig: 1 Capsule(s) (60 mg) by mouth once daily	Depression and pain
Efavirenz-Emtricitabin-Tenofov (ATRIPLA®) 600-200-300mg Tablet Sig: 1 Tablet(s) by mouth once daily at bedtime	HIV
Famotidine 20mg Tablet Sig: 1 Tablet(s) (20 mg) by mouth twice daily as needed	GERD
Fluticasone-Salmeterol (Advair Diskus®) Inhalation 250-50mcg/dose Disk with Device Sig: 1 Inhalation by mouth twice daily	COPD
Gabapentin (Neurontin®) 800mg Tablet Sig: 2 Tablet(s) (1,600 mg) by mouth twice daily per Jennifer	Pain
Glucose (BD Glucose®) 5gram Tablet, Chewable Sig: 1 Tablet(s) (5 gram) by mouth as needed	Hypoglycemia
Insulin Aspart (NovoLOG Flexpen®) Subcutaneous 100unit/mL Insulin Pen	DM

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Sig: 8 Unit(s) subcutaneously three times daily at meals plus sliding scale. Insulin Glargine (Lantus Solostar®) Subcutaneous 100 unit/mL(3 mL) Insulin Pen Sig: 58 Unit(s) subcutaneously daily at bedtime Insulin Needles (Novofine 32®) Miscell. (Med.Supl.;Non-Drugs) 32 gaugex 1/4" Needle Sig: 1 Needle(s) four times daily Insulin Syringe-Needle U-100 Miscell. (Med.Supl.;Non-Drugs) 1/2 mL31 x 5/16" Syringe Sig: 1 Syringe(s) subcutaneously as directed Dispose of syringe in a Sharps container. Ketoconazole (Nizoral®) Topical 2% Shampoo Sig: Shampoo as directed topically three times weekly Meloxicam 7.5mg Tablet Sig: 1 Tablet(s) (7.5 mg) by mouth once daily Naloxone (Narcan®) Nasal 4mg/actuation Spray, Non-Aerosol Sig: 1 Spray(s) alternating nostril every 2 to 3 minutes as needed If the first dose wears off may repeat dose in alternate nostril every 2 to 3 minutes. Call 911 emergency medical care. Use for narcotic overdose.	DM DM DM Fungal infection Pain Opioid reversal

19-

Patient Strengths/protective factors	Risk factors & Adverse Childhood Events
Identifies family support: sisters, aunt and son Self-initiated referral Has continued to engage in services	Continues to inject Suboxone Multiple chronic disease states with poor self-care

20- Describe any cultural factors that may have an impact on this patient's situation (e.g. beliefs about indigenous healing practices, cultural prohibitions of discussing illness, etc.): None identified

21- Labs (as indicated): Include summary of urine testing or last urine drug screen result

1-22-18 HIV1 Load Not DetectedHIV1 Log Not Detected

1-22-18 HgbA1c 8.0

3-1-18- Intake UDT- positive for non-prescribed buprenorphine

5-1-18 (ER visit for welfare check): barbiturates only.

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22-Prescription Monitoring Program Pertinent Findings:

Ambien 10 mg #30 with one refill on 4/27/18 (not our prescriber)

Prior to that Suboxone 4 mg bid (3/23/18-4/9/18)

23-Proposed Diagnoses:

Cocaine Use Disorder - Severe - 304.20 (F14.20) Patient met 11 out of 11 criteria.

Stimulant Use Disorder - Severe - 304.40 (F15.20) Patient met 11 out of 11 criteria.

Opioid Use Disorder - Severe - 304.00 (F11.20) Patient met 11 out of 11 criteria.

Sedative Use Disorder - Severe - 304.10 (F13.20) Patient met 11 out of 11 criteria.

Depression

Multiple chronic medical conditions

24-Patient Goals for Treatment:

What are your top 3 goals for treatment?

1. To quit other drugs
2. To quit shooting drugs
3. Better my health

25- Proposed Treatment Plan:

Patient was started on Suboxone, Day 1 induction on 3/27/18, but by 4/3/18 he was found to be injecting his films. "He did report to Dr. X that he had injected his Suboxone on Saturday and Sunday. He cut a small piece off the 4mg and let it dissolve in 15 cc of distilled water and he does agree that it's the injecting and the needle that is the hook for him. He

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reports that sometimes he just injects distilled water. He is wanting to work with us and he is not taking any other substances other than the Suboxone. He is willing to do the Vivitrol if that is recommended."

From 4/3/18 to 4/16/18, he was maintained on daily Suboxone administered at the clinic Monday-Friday with take-home doses only on Saturday and Sunday.

Entered inpatient detox on 4/16/18 with discharge on 4/25/18 to facilitate initiation of Vivitrol.

5/1/18 was date of welfare check.

Currently, he is concerned that he is reacting to Vivitrol with complaints of nausea, diarrhea, chills, h/a, RLS, and difficulty sleeping. He is continuing to report that he does not want the Vivitrol injection. Second injection is due: 5/21/18.

He is scheduled for weekly counseling sessions.

Follow-up plan: Continue naltrexone with increased emphasis on control of DM. Encourage involvement in peer support. Re-enforce need for counseling as a primary focus of treatment.

5/21: Patient was seen. He declined Vivitrol, but was open to oral naltrexone. Started on naltrexone 50 mg po qd.

5/22: Patient informed of need to attend weekly Early Recovery Skills group. Patient did not attend group today.

5/23: Patient calls to report "allergic reaction" to po naltrexone. Naltrexone stopped. Claritin started.

5/24: Patient presented for appointment with selfies of the reported allergic reaction. The pictures appear to be show puffed out cheeks holding air in his mouth. No evidence of lip swelling. Declines any further naltrexone. States he has not been obtaining buprenorphine from street sources but UDT done at time of appointment is + for buprenorphine. Patient later indicates he has been buying buprenorphine but indicates he is not injecting. Patient did not attend group today.

5/29: Treatment staffing: In view of continued struggles with medication and non-attendance for counseling groups, recommendation made for transfer to OTP for methadone. Patient had success with methadone program earlier in his life. Patient did not attend group today.

5/30: Patient informed of treatment recommendation for transfer to methadone program. He is agreeable. Care coordinator working on transfer of care.

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2. Wanting to cut down or quit but not being able to do it
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5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use

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8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

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Alcohol misuse in the setting of daily prescription opioid use or MAT

Christopher R. Nicholas, Ph.D.

Assistant Professor

Department of Family Medicine & Community Health

University of Wisconsin School of Medicine & Public Health

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Overview

- Prevalence of alcohol and opioid use
- Complications from alcohol and opioid use
- Pain and alcohol use
- Neurobiology of pain and alcohol use
- Assessment
- Intervention

Prevalence

- The Drug Abuse Warning Network (DAWN)
  - Alcohol was involved in 18.5% and 22.1% of opioid (prescription & non-prescription) related ED visits and deaths, respectively
  - ED visits highest among persons aged 30-44 and 45-50 and deaths were highest in persons aged 40-49 and 50-59.
  - Alcohol was involved in 11% and 10% of buprenorphine and methadone (non-medically used) related ED visits, respectively.

Complications and risk of combined alcohol and opioid use

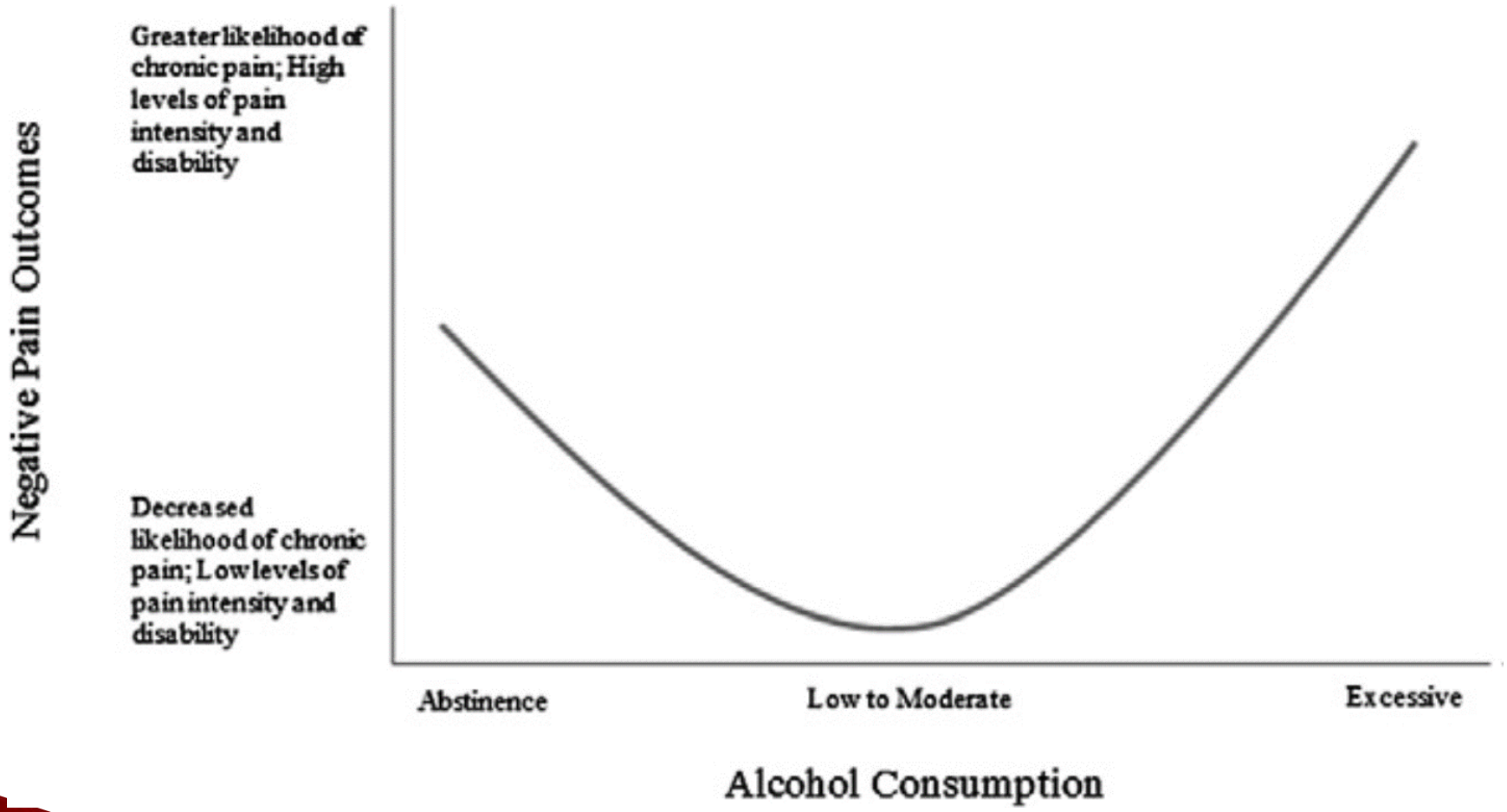
- Respiratory depression is a potentially fatal complication mediated through u-opioid receptor action in brainstem (medulla, locus coeruleus of the pons)
  - Exacerbated by simultaneous alcohol intake (van der Schrier, 2017)

- Cross-tolerance: may affect pain-inhibitory effects of opioids (Levine et al., 1983; He & Whistler, 2011)

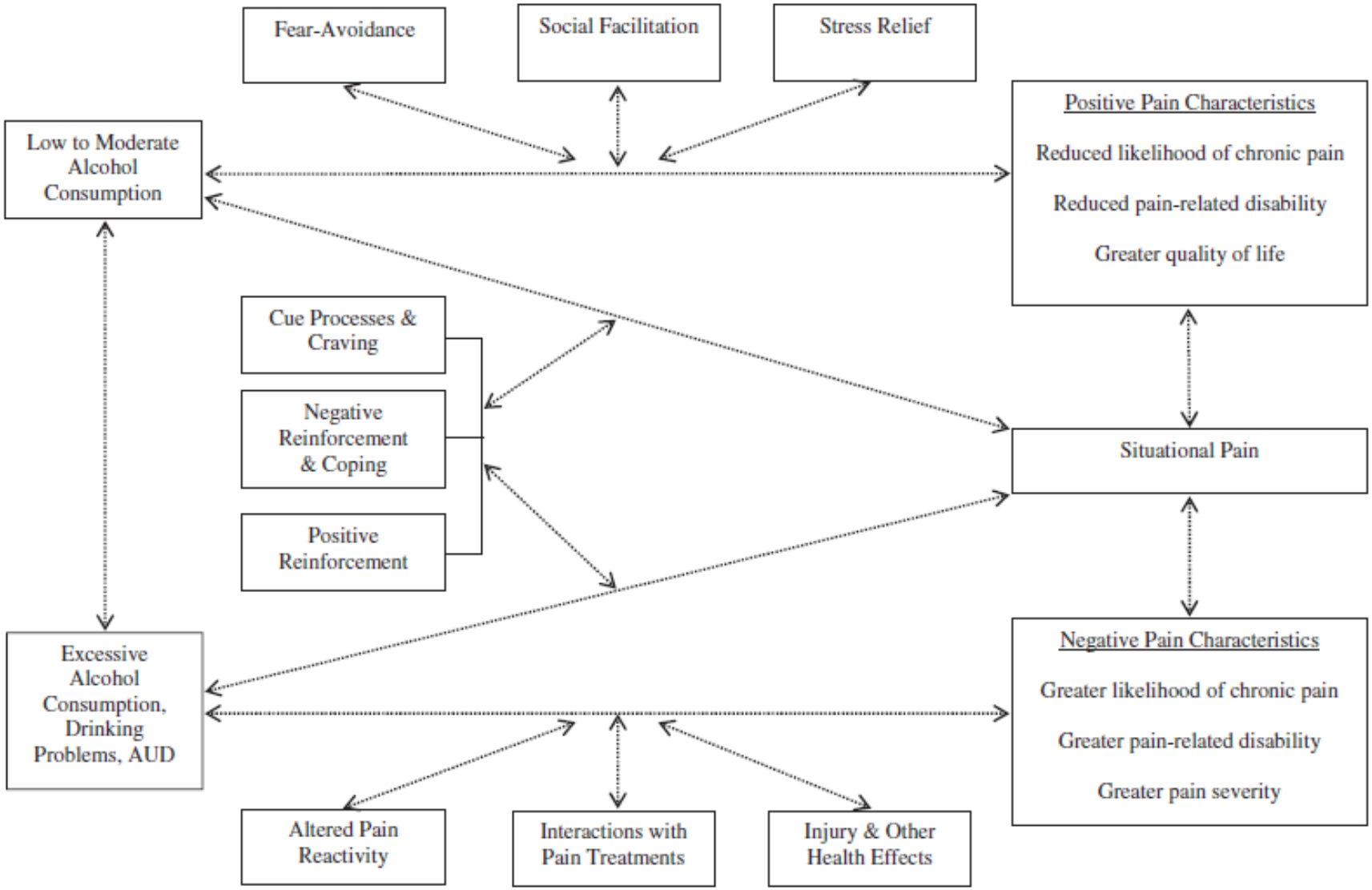
Pain and alcohol use

- Alcohol induced pancreatitis, peripheral neuropathy, chronic joint pain, traumatic injury, or falls.
- Back or neck pain patient up to 2X more likely to have an AUD (Von Korff et al., 2005)
- 73% of AUD patients in residential treatment reported mod-to-severe pain (Larson et al., 2007)
- Mod alcohol use associated with a 40%–70% reduced likelihood of chronic back or neck pain or RA (Kondo et al., 2007; killgate et al., 2009)
- Acute alcohol administration may only decrease pain in problem drinkers or AUD (Cutter, Jones, Maloof, & Kurtz, 1979)
- Hyperalgesic responses associated with withdrawal and increased pain may precede relapse (e.g., Ditre et al., 2011)

Possible curvilinear relationship between alcohol & chronic pain

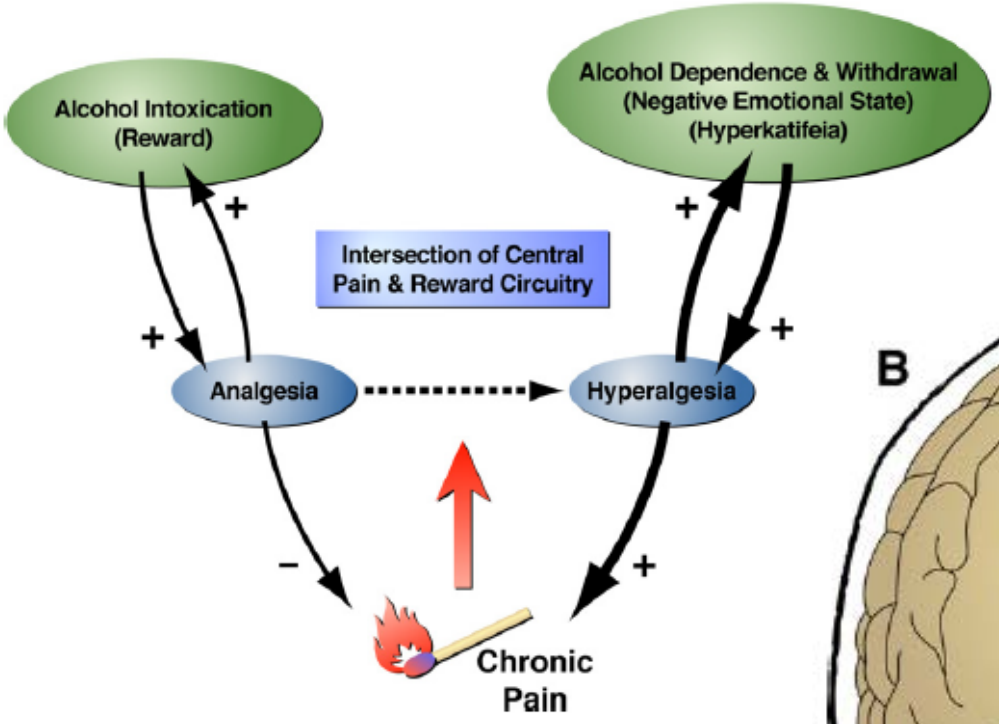


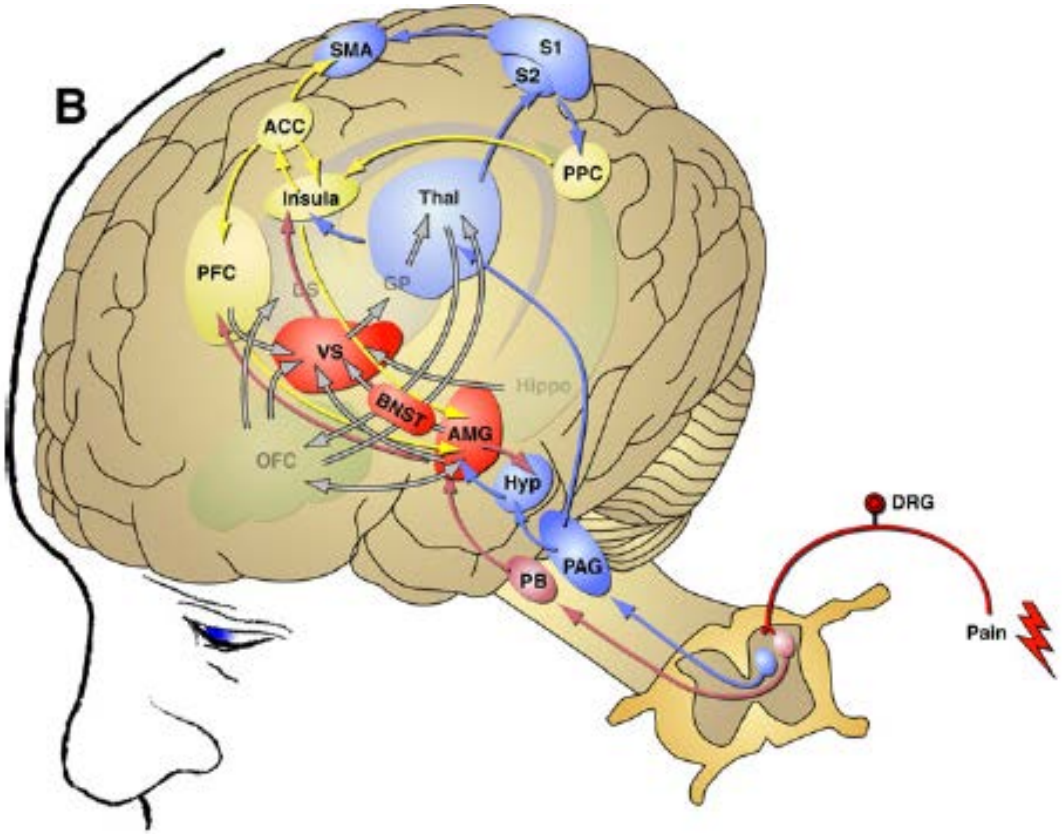
Zale et al., 2015



Zale et al., 2015

Pain and reward circuitry





Elgi et al., 2012

Screening and Assessment

- Prior SUD is major risk for misuse of opioids (Ives 2001)
- If intoxicated may see somnolence or stupor, miosis, respiratory depression or apnea
- May need to introduce periodic testing of opioid biomarkers
- Urine screens for heavy alcohol use: blood alcohol level or serum carbohydrate deficient transferrin.
- Biomarkers of alcohol-related liver disease, hepatic function testing, complete blood cell count (including red cell indices, such as mean cell volume and red cell distribution width), and electrolytes
- Check PDMP more regularly

Screening and Assessment

- AUDIT, CAGE, PHQ-9, GAD, trauma
- Five A's (Ask, Advise, Assess, Assist, Arrange)
- Functional analysis of alcohol/opioid/pain of internal and external triggers: where, what, when/whom?
- Pain: Reassess pain, function, and pain management regime
- Pain catastrophizing, unrealistic expectations about pain, social support around pain
- Allay patient's fears that their pain or OUD will continue to be treated

Intervention

- Ideally engage in an interdisciplinary pain/substance rehabilitation program or increase communication between various specialties
- Education, PT, medications, addiction treatment (brief intervention to IOP or residential)
- Psychotherapy: MI, CBT, ACT, biofeedback, family therapy, brief psychodynamic, hypnosis or guided imagery, somatic experiencing, behavior modification, mindfulness, trauma-focused
- Medications: Acamprosate, Naltrexone (if not on opioids), Gabapentin

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} **Physical Dependence ≠ Use Disorder**

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2–3 = mild
4–5 = moderate
≥ 6 = severe